STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN.

I. General

A. The state agency, the Department of Social and Health Services (department), will take whatever measures are necessary to assure appropriate audit of records wherever reimbursement is based on costs of providing care or service, or fee plus cost of materials.

B. The department maintains data indicating the allowed charges for claims made by providers. Such data will be made available to the Secretary of Health and Human Services upon request.

C. Payment methods are identified in the various sections of Attachment 4.19-B, and are established and designed to enlist participation of a sufficient number of providers in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent these are available to the general population. Payment for extraordinary items or services under exception to policy is based upon department approval and determination of medical necessity.

D. Participation in the program is limited to providers of services who accept, as payment in full, the amounts paid in accordance with the fee structure.

E. State payment will not exceed upper limits as described in regulations found in 42 CFR 447.300 through 447.371. Any increase in a payment structure that applies to individual practitioner services is documented in accordance with the requirements of 42.CFR 447.203.

F. Providers, including public and private practitioners, are paid the same rate for the same service, except when otherwise specified in the State Plan.

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II. Clinic Services

A. Unless otherwise specified in this section, Medicaid provider clinics are reimbursed at a fee-for-service rate established by the state.

Specialized clinics are reimbursed only for services the clinic is approved to provide.

B. Unless otherwise specified in this section, Medicaid provider clinics are reimbursed at a fee-for-service rate established by the state. Specialized clinics are reimbursed only for services the clinic is approved to provide.

Dialysis Services: Effective September 1, 2002, reimbursement for hemodialysis and Intermittent Peritoneal Dialysis is provided under a statewide composite rate of $197.45 and is limited to 14 sessions per calendar month. Reimbursement for Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuous Cycling Peritoneal Dialysis (CCPD) is provided under a statewide composite rate of $84.62 and is limited to one session per day, not to exceed 31 per calendar month. The composite rate includes all standard equipment, supplies, and services necessary for dialysis. Future vendor rate increases will be reflected in future state plan amendments.

Dialysis services provided by freestanding facilities are clinic services and are reimbursed according to the provisions of 42 CFR 447.321.

C. Rural Health Clinics

Effective January 1, 2001, the payment methodology for Rural Health Clinics (RHCs) conforms to Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. Under BIPA 2000, all RHCs that provide services on or after January 1, 2001 and each succeeding year are reimbursed on a prospective payment system (PPS) or an accepted alternative methodology.

BIPA 2000 allows for payment to an RHC using an alternative methodology to the PPS, as long as the alternative methodology results in a payment to the clinic that is at least equal to the PPS payment rate.

This alternative methodology must be agreed to by the State and the RHC, and documentation of each clinic's agreement must be kept on file by the State. If an individual RHC does not agree to be reimbursed under this alternative methodology, the RHC will be paid under the BIPA PPS methodology.

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II. Clinic services (cont.)

Effective for dates of service January 1, 2001 through December 31, 2001, each RHC agreed to an alternative methodology that provided payments at least equal to the amount the clinic was entitled to under BIPA PPS

Effective for dates of service on and after January 1, 2002, the State fully implemented the PPS methodology as described in BIPA 2000.

Using the PPS methodology, the payment is set prospectively using a weighted average of 100 percent of the clinic's total reasonable costs for all Medicaid-covered services as defined in the State Plan for calendar years 1999 and 2000, and adjusted for any increase or decrease in the scope of services furnished during calendar year 2001, to establish a separate encounter rate. A clinic may choose to allocate applicable costs and encounters to specific services such as dental, mental health, etc., and establish a separate encounter rate for these services. A base encounter rate for these services will be set in the same method. The encounter rates are determined using Medicare's audited cost reports, and each year's rate is weighted by the total reported encounters. The formula used to calculate the base encounter rate is as follows:

$$\text{Base Encounter Rate} = \frac{(\text{1999 Rate} * \text{1999Encounters}) + (\text{2000 Encounters})}{(\text{1999 Encounters} + \text{2000 Encounters})}$$

A change in scope of service is defined as a change in the type, intensity, duration and/or amount of services. A change in the scope of service will occur: if (1) the clinic adds or drops any service that meets the definition of RHC service as defined in section 1905(a)(2)(B) of the Social Security Act; and, (2) the service is included as a covered Medicaid service as described in the State Plan Amendment.

The clinic is responsible for notifying the RHC Program Manager in writing of any changes during the calendar year, no later than 60 days before the effective date of the change. Within 60 days of notification, the State will verify the change meets the definition of change of scope of service.

If the change represents a decrease in scope of service, the State will recalculate the base encounter rate by decreasing it by the average cost per encounter detailed in the clinic's 1999 and 2000 cost reports.

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II. Clinic Services (cont.)

If the change represents an increase in scope of service, the State will recalculate the base encounter rate on an interim basis by increasing it by the average statewide cost per encounter as detailed in the 1999 and 2000 cost reports from other clinics that provide the service.

This interim rate will be effective the date the new service is implemented and fully available to Medicaid clients. Once the clinic can demonstrate its true costs of providing the service, it must submit adequate documentation of the costs to the State. The State will perform a desk review of the costs to determine if the costs are reasonable and necessary, and adjust the interim rate by the accepted cost per encounter to establish a final encounter rate.

Beginning in calendar year 2002 and any year thereafter, the encounter rate is increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted for any increase or decrease within the clinic's scope of services. The MEI for primary care services is applied to all types of encounter rates established for the clinic.

Rural Health Clinics receiving their initial designation after January 1, 2001, are paid an average encounter rate of other clinics located in the same or adjacent area with a similar case load, on an interim basis until the clinic's first audited Medicare cost report is available.

Once the audited report for the clinic's first year is available, the new RHC's encounter rate is set at 100% of its costs as defined in the cost report. The new RHC will receive this rate for the remainder of the calendar year during which the audited cost report became available, and will receive the MEI increase each year thereafter using the defined methodology.

For clients enrolled with a managed-care contractor, the State will pay the clinic a supplemental payment on a per-member-per-month basis, in addition to the amount paid by the managed-care contractor, to ensure the clinic is receiving the full amount it is entitled to under the PPS methodology.

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II. Clinic Services (cont.)

The supplemental payment is the difference between the payments the clinic received from the managed-care contractor and the payments the clinic would have received under the PPS methodology. This supplemental payment is paid at least every four months. Until the State obtains final audited cost reports for 1999 and 2000 for all RHCs, and establishes final base encounter rates, the clinics are paid using an interim encounter rate comprised of the most current available cost information.

The State will perform a reconciliation and settle any overpayments or underpayments made to the clinics, retroactive to January 1, 2002.

Covered services for Medicaid-Medicare patients are reimbursed as detailed in Supplement 1 to Attachment 4.19 (B), pages 1, 2, and 3.

C. Non-hospital-owned Freestanding Ambulatory Surgery Centers

Freestanding ambulatory surgery centers (ASC) are reimbursed a facility fee based on Medicare's Grouper, except for procedures Medicare has not grouped; in which case, DSHS groups the service to a like procedure that Medicare has grouped.

All procedures that the department reimburses to an ASC are assigned a grouper of one through eight (1-8). Each of these groupers is assigned a set fee. The department pays the lesser of the usual and customary charge or the grouper fee based on a department fee schedule.

III. Physician Services

A. For physician services the department pays the lesser of the usual and customary charge or a fee based on a published department fee schedule. The usual and customary charge is the fee charged by a physician to his/her patients. All physicians, including public and private practitioners, are paid the same rate for the same service.

B. Maximum allowable fees are established and updated using the Resource Based Relative Value Scale (RBRVS) methodology as adopted in the Medicare Fee Schedule Data Base (MFSDB).

The MFSDB relative value units (RVU) are geographically adjusted each year by the statewide average Geographic Practice Cost Indices (GPCI) for Washington State as published annually in the Federal Register. The adjusted RVU are multiplied by a service-specific conversion factor to derive a fee for each procedure.

The department currently has unique conversion factors for Children's primary health care services, including office visits and EPSDT screens; Adult primary health care, including office visits; Maternity services, including antepartum care, deliveries, and postpartum care; Anesthesia services; Laboratory services; Radiological services; Surgical services; Consultations; etc. The department establishes budget neutrality each year when determining its conversion factors, then updates the conversion factors by any increase or decrease mandated by the Legislature.

C. When no MFSDB RVU exists, the department may apply a set fee to the procedure or determine payment based on documentation by the provider. The department determines a set fee for drugs administered in the provider's office based on a percentage of the Average Wholesale Price (AWP) as determined by Medicare. The department determines a set fee for those professional procedures without an assigned RVU by either assigning a proxy RVU based on similar procedures, or by reviewing the medical documentation of the procedure and paying a percentage of the provider's usual and customary charge. Those procedures without RVU's are updated annually with publication of the MFSDB RVU in the Federal Register.

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III. Physicians Services (continued)

D. Trauma Center Physician Services - Trauma Centers are designated by the State of Washington Department of Health (DOH).

Trauma center physician services are paid using an enhanced payment based on the trauma care fund established by the State of Washington in 1997 to improve the compensation to physicians and designated trauma facilities for care to Medicaid trauma patients. Currently, the fund is providing reimbursements at an increased percentage of the base Medicaid rate for physician services provided under fee-for-service to trauma patients with an Injury Severity Score (ISS) that meets or exceeds the threshold set by the department. The additional payment is paid as the claim for the case is paid, and is not a lump-sum supplemental payment. The percentage enhancement is reviewed and adjusted annually based on the amount of trauma care funds available and the volume of trauma cases eligible for the higher reimbursement.

E. Out-of-State Physician-related Care.

For medically necessary treatment of emergencies that occur while a client is out-of-state, DSHS pays the lesser of the usual and customary charge or a fee based on a published department fee schedule.

For physician related services in those instances when DSHS makes referrals to out-of-state hospitals, after MAA's Medical Director or designee approved an Exception to Rule for the care not available instate:

1. In absence of a contract, DSHS pays the lesser of the usual and customary charge or a fee based on a published department fee schedule.

2. When DSHS is successful negotiating a contract for such services, the services are paid using a negotiated contract rate. DSHS first negotiates for the rate mentioned above, then for the lesser of the usual or customary charge or the other state's Medicaid or Medicare rate, and finally for the best rate possible beyond the other tiers.

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IV. Pharmacy Services

A. General Information:

1. The department reimburses only for prescription drugs provided by manufacturers that have a signed drug rebate agreement with the Department of Health and Human Services (HHS).

   Prescriptions for drugs may be filled and refilled at the discretion of the prescriber. For those drugs specified by the department, prior approval is required.

2. Payment for drugs purchased in bulk by a public agency is made in accordance with governmental statutes and regulations governing such purchases.

3. Each Medical Assistance client is granted the freedom to choose his or her source of medications, except when the client is covered under a managed care plan that includes the drug benefit.

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B. Upper Limits for Multiple-Source Drugs:

1. The reimbursement amount for a multiple-source drug for which CMS has established a specific federal upper limit (FUL) will be adopted–except when the FUL is lower than the pharmacies' actual acquisition cost for products available in Washington state.

   Based on information provided by representative pharmacy providers, a maximum allowable cost (MAC) is chosen.

   The chosen MAC is the lowest amount sufficient to cover in-state pharmacies' actual acquisition cost. Payments for multiple-source drugs for which CMS has set upper limits do not exceed, in the aggregate, the prescribed upper limits plus reasonable dispensing fees.

2. The department may establish a MAC for other multiple-source drugs that are available from at least three manufacturers/labelers. The MAC established does not apply if the prescriber certifies that a specific brand is "medically necessary" for a particular client.

3. Automated maximum allowable cost (AMAC) pricing applies to multiple-source drugs which are not on CMS's federal upper limits (FUL) list or the department's MAC list but are produced by three or more manufacturers/labelers, at least one of which has signed a federal drug rebate agreement. AMAC reimbursement for all products within a generic code number sequence is at the estimated acquisition cost (EAC) of the third lowest priced product in that sequence, or the EAC of the lowest priced drug under a federal rebate agreement in that sequence, whichever is higher. AMAC is recalculated each time there is a pricing update~~s~~ to any product in the sequence.

4. The department will determine EAC by periodically determining the pharmacies' average acquisition costs for a sample of drug codes. The average cost will be based on in-state wholesalers' published prices to subscribers, plus an average upcharge, if applicable.

   The department will pay the EAC for a multiple source product if the EAC is less than the MAC/AMAC established for that product.

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IV. Pharmacy Services (cont.)

C. Upper Limits for "Other" drugs:

1. An "other" drug is defined as a brand name (single source) drug, a multiple-source drug where significant clinical differences exist between the branded product and generic equivalents, or a drug with limited availability.

2. Payments for "other" drugs are based on Average Wholesale Price (AWP) less a specified percentage. AWP is determined using price information provided by the drug file contractor.

3. See Supplement A for current EAC percentages.

IV. Pharmacy Services (cont.)

D. Dispensing Fee Determination:

1. The department sets pharmacy dispensing fees based on results of periodic surveys.

2. The current dispensing fee payment system is multi-tiered. The dispensing fee paid to a pharmacy depends upon that pharmacy's total annual prescription volume (both Medicaid and non-Medicaid), as reported to the department. The exception to this is the contracted mail-order delivery service for prescription drugs; the dispensing fee is agreed upon during the Request For Proposal (RFP) process.

3. Pharmacies providing unit dose delivery service are paid the department's highest allowable dispensing fee for unit dose prescriptions dispensed. All other prescriptions filled by these pharmacies are paid at the dispensing fee level applicable to their annual prescription volume. The exception to this is the contracted mail-order delivery service for prescription drugs; the dispensing fee is agreed upon during the Request For Proposal (RFP) process.

4. A dispensing fee is paid for each ingredient in a compound prescription.

5. See Supplement A for current dispensing fees.

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IV. Pharmacy Services: (continued)

E. Mail Order Delivery Service for Prescription Drugs

The state contracts for a mail-order delivery service for prescription drugs through a competitive bid process. This service is available to all fee-for-service Medicaid clients statewide. Clients have the option of having prescriptions filled at either a local retail outlet of their choice or by the mail-order contractor. All policies and procedures that apply to retail pharmacies also apply to the mail-order contractor, except for the following:

1. The mail-order contractor is reimbursed at a mutually agreed upon level that is less than reimbursement provided to local retail pharmacies; and

2. If authorized by the prescriber, the mail-order contractor may dispense the following drugs in up to a ninety-day supply:

   a. Preferred drugs identified by the state;

   b. Generic drugs; and

   c. Drugs that do not require prior authorization or expedited prior authorization.

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V. Medically Necessary Durable Medical Equipment and Supplies, and Medically Necessary Non-Durable Medical Equipment and Supplies

Qualified providers under the home health benefit are paid for covered medically necessary durable medical equipment and supplies (DME) and medically necessary non-durable medical equipment and supplies (Non-DME), repairs, and related services provided to eligible clients. The department pays the lesser of the usual and customary charge or a fee based on a department fee schedule.

Items not included on the uniform fee schedule are not covered. Requests for non-covered items will be reviewed according to the department's "Exception to Rule" guidelines.

The department does not pay DME providers separately for services in this category that are included as part of the payment for another treatment program. For example, all items required during in inpatient stay are paid through the inpatient payment.

The department's reimbursement for covered DME includes any adjustments or modifications to the equipment that are required within three months of the date of delivery (not to include adjustments related to a change in the client's medical condition), fitting and set-up, and instruction to the client or client's caregiver in the appropriate use of the equipment and/or supplies.

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VI. Dental Services and Dentures

A. The department pays directly to the specific provider the lesser of the usual and customary charge or a fee based on a department fee schedule, for dental services and dentures provided within their specific scope of practice by dentists, dental hygienists, and denturists throughout the state. There are no geographical or other variations in the fee schedule.

B. The usual and customary charge is defined as that fee usually charged for a given service by an individual dentist, dental hygienist, or denturist to private patients (i.e., that provider's usual fee) and which fee is within the range of usual fees charged by dentists, dental hygienists, or denturists of similar training and experience.

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VII. Optometrists Services (Vision Care Services and Eyeglasses)

A. Ophthalmologists, optometrists, and opticians

Ophthalmologists, optometrists, and opticians are authorized to provide vision care services within their scope of practice.

The department pays the lesser of the usual and customary charge or a fee based on a department fee schedule for authorized medically necessary vision care services.

B. Frames, lenses and contact lenses

Frames, lenses and contact lenses must be ordered from the department's contractor.

The amount paid for authorized medically necessary frames, lenses and contact lenses is the department's contracted price with the contractor.

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VIII. Institutional Services

A. Outpatient hospital services

Duplicate payment for services does not occur. Non-Critical Access Hospital (CAH) outpatient hospital services are reimbursed utilizing either:

1. The department's Medicaid Outpatient Prospective Payments System (OPPS), in which each service is individually reimbursed using one of the following payment methods: Ambulatory Payment Classifications (APC); fee schedule; or "hospital outpatient rate" (the APC method is the primary payment method in OPPS); or

2. For non-CAH hospitals and covered services exempt from the department's Medicaid OPPS method, a fee schedule or a "hospital outpatient rate".

   For non-CAH hospitals and covered services not paid using the OPPS or the "hospital outpatient rate", the department pays the lesser of the usual and customary charge or a fee based on a department fee schedule for: covered procedures when a technical component has been established in the Medicare Fee Schedule Data Base (MFSDB); and procedures specifically identified by the department. Fees for these services are set using the Resource Based Relative Value Scale (RBRVS) methodology.

   Services paid using the department's fee schedule include, but are not limited to, laboratory/pathology, radiology and nuclear medicine, computerized tomography scans, magnetic resonance imaging, other imaging services, physical therapy, occupational therapy, speech/language therapy, EKG/ECG/EEG, other diagnostics, synagis, sleep studies, and other hospital services as identified and published by the department.

   The "hospital outpatient rate" is a hospital-specific rate having as its base the hospital's inpatient ratio of costs-to-charges (RCC) rate adjusted by an outpatient adjustment factor that factors annual cost and charge level changes into the rate. The "hospital outpatient rate" is used to reimburse under OPPS as explained earlier in this subsection, or for non-CAH hospitals exempt from the department's OPPS, for all other covered outpatient services (those not mentioned in the previous paragraphs as covered by fee schedule) on the hospital's outpatient claim.

3. Trauma Center Services

   Trauma Centers are designated by the State of Washington Department of Health (DOH) into five levels, based on level of services available. This includes Level 1, the highest level of trauma care, through Level V, the most basic trauma care.

   Level of designation is determined by specific numbers of health care professionals trained in specific trauma care specialties, inventories of specific trauma care equipment, on-call and response time minimum standards, quality assurance and improvement programs, and commitment level of the facility to providing trauma-related prevention, education, training, and research services to their respective communities.

   Level I, II, and III trauma centers services will be reimbursed using an enhanced payment based on the trauma care fund established by the State of Washington in 1997 to improve the compensation to designated outpatient hospital trauma facilities for care to Medicaid trauma patients.

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VIII. Institutional Services (cont.)

A. Outpatient hospital services, Trauma Center Services (cont.)

Currently, the fund is providing reimbursements to Level I, II, and III trauma centers through lump-sum supplemental payments made quarterly. The payment each hospital receives is proportional to the percentage that the department pays in total to all Level I, II, and III trauma centers quarterly for fee-for-service trauma case claims. Each qualifying hospital's payment percentage is then applied to the department's total enhanced trauma supplemental funds available for the quarter, to determine the hospital's proportional payment from the quarter's trauma supplemental. A fee-for-service case qualifies for trauma designation if care provided has an Injury Severity Score (ISS) that meets or exceeds the threshold set by the department. The percentage enhancement is reviewed and adjusted at least annually, based on the amount of trauma care funds available and the volume of trauma cases eligible for the higher reimbursement. Level IV and V trauma centers are given an enhanced payment outside of Medicaid by the State's Department of Health using only State funds.

B. Ambulatory surgery centers that are hospital-owned facilities.

Ambulatory surgery centers (ASC) that are hospital-owned (hospital-based) will be reimbursed as part of the hospital, using the payment methods used to pay hospital outpatient claims.

C. Inpatient vs. Outpatient Stay Policy

Through October 31, 2004, stays of less than, approximating, or exceeding 24 hours where an inpatient admission was not appropriate will be reimbursed on an outpatient basis. Stays of less than 24 hours involving the death of the patient, transfer to another acute care hospital, a delivery, or initial care of a newborn are considered inpatient and are reimbursed under the respective inpatient payment method designated for the hospital and/ or the covered services.

On and after November 1, 2004, a new clinical-based inpatient vs. outpatient stay determination rule is in effect.

An inpatient stay is an admission to a hospital based on an evaluation of the client using objective clinical indicators for the purpose of providing medically necessary inpatient care, including assessment, monitoring, and therapeutic services as required to best manage the client's illness or injury, and that is documented in the client's medical record.

An outpatient hospital stay consists of outpatient hospital services that are within a hospital's licensure and provided to a client who is designated as an outpatient based on an evaluation of the client using objective clinical indicators for the purpose of providing medically necessary ambulatory care, including assessment, monitoring, and therapeutic services as required to best manage the client's illness or injury, and that is documented in the client's medical record.

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VIII. Institutional Services (cont.)

D. Critical Access Hospital (CAH) Program

1. Critical Access Hospital (CAH) program means a Title XIX and state inpatient and outpatient hospital reimbursement program through which hospitals approved by the department for the CAH program, that meet the Medicare qualifications for CAH designation, and are approved by the Department of Health as critical access hospitals, are reimbursed by the department for Title XIX and state program services through a cost settlement method.

2. Through this cost settlement payment method, department-approved hospitals participating in the state's Title XIX CAH program receive prospective payment for outpatient hospital services based on an Outpatient Departmental Weighted Cost-to-Charge (ODWCC) ratio.

   Post-period cost settlement is then performed for fee-for-service covered services subsequent to the hospital fiscal year (HFY) end, using HFY claims data and data from the CMS 2552 Medicare Cost Report. Settlements are performed using the initially submitted CMS 2552 Medicare Cost Report and the finalized CMS 2552 Medicare Cost Report.

   Healthy Options services are reimbursed using rates negotiated between the hospitals and the Healthy Options managed care plans. Healthy Options managed care plans receive premiums from the state that are actuarially developed to cover these payments rates. No cost settlement is performed on Healthy Options services.

E. Medicare-Related Policies for Outpatient Hospital Payments

For payment methods related to the Medicare Part A, Part B, and Part C deductibles, coinsurance, and/or co-pays, please refer to Supplement 1 to Attachment 4.19-B, as updated. Medicare crossovers refer to hospital patients who are eligible for Medicare benefits and Medicaid. For these clients, the state considers the Medicare Part B Outpatient Hospital payments to be payment in full. The state will pay the Medicare deductible and co-insurance related to a Medicaid clients Medicare Part B outpatient hospital claim only up to the maximum payment level calculated using the Medicaid "hospital outpatient rate" described in subsection VIII. A. above, and Supplement 1 to Attachment 4.19-B. However, the maximum payment level will exclude any trauma enhanced payment amount.

If the Medicare Part B covered charges and payments are combined with the Medicare Part A inpatient covered charges and payments on a Medicare claim, obscuring the Part B charges and payment amounts, the total Medicaid payment to a Medicaid provider will be calculated as described in Attachment 4.19-A for Medicare crossovers, and Supplement 1 to Attachment 4.19-B, for Medicare Part A services. The total Medicaid payment to a Medicaid provider for Medicare Part C outpatient hospital-related care provided to a Medicaid client will be calculated as described in Supplement 1 to Attachment 4.19-B.

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IX. Other Noninstitutional Services

A. Home Health

1. Home Health Agencies are reimbursed per-visit for services provided by acute nursing staff, physical therapy, occupational therapy, speech, hearing and language disorders therapy staff, and home health aides.

The department pays the lesser of the usual and customary charge or a fee based on a department fee schedule for these services.

Reimbursement rates are determined using a historical base for the per-visit rates by profession, using the Medicare Metropolitan Statistical Area fees. Each year the State updates those per-visit rates using the state's annually published vendor rate adjustment factor.

2. Other Home Health-Related Services and Supplies

Oxygen and respiratory therapy services are paid by the department at the lesser of the usual and customary charge or a fee based on a department fee schedule.

Medical nutrition and related equipment rentals/purchases and supplies, are paid by the department at the lesser of the usual and customary charge or a fee based on a department fee schedule.

Home infusion-parenteral nutrition equipment and supplies are paid by the department at the lesser of the usual and customary charge or a fee based on a department fee schedule.

B. Adult Day Health is a supervised daytime program providing rehabilitative therapy and skilled nursing services. Adult Day Health services are provided to adults with medical or disabling conditions that require the intervention or services of a licensed rehabilitative therapist acting under the supervision of the client's physician. The department reimburses Adult Day Health providers at a flat fee, per-day-per-client rate for all services rendered. Payment will not exceed the prevailing charges in the locality for comparable services under comparable conditions.

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IX. Other Noninstitutional Services (cont.)

C. The department makes payment for transportation to and from medically necessary services covered by a client's medical assistance program as specifically listed below.

1. Ambulance services for emergent situations are paid as an optional medical service through direct vendor payments based on fee-for-service. Payments for medical transportation do not exceed the maximum allowable rates established and published by the department.

2. All non-emergency transportation services, to assure clients have access to and from covered services, are provided using administrative matched dollars in accordance with Section 42 CFR 431.53.

D. Rehabilitative Services

Payment for physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders is described in Section IX. J.

1. Behavior Rehabilitation Services

Payment for behavioral rehabilitation services is on a fee-for-service basis, with one month being the unit of service. Rates are determined using a prospective rate setting system. These rates will be reconciled annually and adjusted as appropriate based upon preceding operating year cost reports.

2. Alcohol/Drug Treatment and Detoxification Services

Payment for inpatient detoxification services provided in freestanding department-approved alcohol/drug treatment centers is on a fee-for-service basis, with one day being the unit of service. The department pays the lesser of the usual and customary charge or a fee based on a department fee schedule. There is no room and board paid for these services.

Payment for outpatient alcohol/drug treatment services is provided to certified facilities on a fee-for-services basis for specific services. The department pays the lesser of the usual and customary charge or a fee based on a department fee schedule. Licensed chemical dependency professionals who are paid by the facility, provide services.

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IX. Other Noninstitutional Services (cont.)

E. Disease Management Programs

The disease management program is a preventive service that provides coverage under the Categorically Needy Program (CNP) to Medicaid clients who receive services through the department's fee-for-service system, and who have one or more of the following diseases: Asthma, Congestive Heart Failure, Diabetes, Chronic Obstructive Pulmonary Disease, and End Stage Renal Disease, or Chronic Kidney Disease.

In accordance with federal interpretation, the disease management contracts are risk contracts. The State uses two methods of payment for the contracted Disease Management programs. Each method of payment has been developed using actuarially sound methodology and does not exceed the amount the State would have paid had disease management services been provided using the fee-for-service system.

1. For the End Stage Renal Disease (ESRD) and Chronic Kidney Disease (CKD) program, the State pays the contractor a monthly capitated fee for each client currently participating in the ESRD/CKD program.

2. For the Asthma, Congestive Heart Failure, COPD, and Diabetes programs, the State pays the contractor a capitated fee based on the total eligible population, and the prevalence of each disease within the total population.

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IX. Other Noninstitutional Services (cont.)

F. Early Periodic Screening, Diagnosis and Treatment (EPSDT)

The department pays the lesser of the usual and customary charge, or a fee based on a department fee schedule for the particular EPSDT service provided. The fee schedule used for payment depends on the type of service being provided.

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IX. Other Noninstitutional Services (cont.)

G. Family Planning Services

The department pays the lesser of the usual and customary charge, or a fee based on a department fee schedule for covered family planning services.

H. Extended Services For Pregnant Women Through the Sixty Days Postpartum Period

Services include, maternity support services, outpatient alcohol and drug treatment, rehabilitation alcohol and drug treatment services, genetic counseling, and smoking cessation counseling. The department pays the lesser of the usual and customary charge, or a fee based on a department fee schedule.

I. Private Duty Nursing Services

The department pays the lesser of the usual and customary charge, or a fee based on a department fee schedule for private duty nursing services.

J. Physical therapy, occupational therapy, and services for Individuals with speech, hearing and language disorders

The department pays the lesser of the usual and customary charge, or a fee based on a department fee schedule for these services.

The department does not pay separately for therapy services that are included as part of payment for other treatments or programs.

K. Hearing Services and Hearing Aids

The department pays the lesser of the usual and customary charge or a fee based on a department fee schedule for authorized medically necessary services and hearing aids.

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IX. Other Noninstitutional Services (cont.)

L. Prosthetics and Orthotics

Qualified providers are paid for covered medically necessary prosthetics and orthotics provided to eligible clients. The department pays the lesser of the usual and customary charge, or a fee based on a department fee schedule.

Items not included on the uniform fee schedule are not covered. Requests for non-covered items will be reviewed according to the department's "Exception to Rule" guidelines.

The department does not pay providers separately for services in this category that are included as part of the payment for another treatment program. For example, all items required during in inpatient stay are paid through the inpatient payment.

The department's reimbursement for covered prosthetics and orthotics includes any adjustments or modifications to the equipment that are required within three months of the date of delivery (not to include adjustments related to a change in the client's medical condition), fitting and set-up, and instruction to the client or client's caregiver in the appropriate use of the equipment, device, and/or supplies.

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X. All Other Practitioners

"All other practitioners" refers to other practitioners as described in section 6.d of Attachments 3.1-A and 3.1-B.

The department pays the lesser of the usual and customary charge, or a fee based on a department fee schedule.

Freestanding birthing centers are reimbursed utilizing a contracted facility fee, using state funds only. The birthing center facility fee is consistent across birthing centers. This facility fee is based on statewide historical cost and is paid by fee schedule.

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XI. Prepaid Capitation Arrangements

The cost of providing a given scope of services to a given number of individuals under a capitation arrangement will not exceed the cost of providing the same services while paying for them under the requirements imposed for specific provider services.

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XII. Laboratory and Radiology Services

1. Payments for laboratory and pathology services are made at a percentage of Medicare's clinical laboratory fee schedule.

2. The department pays the lesser of the usual and customary charge, or a fee based on a department fee schedule for radiology services.

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XIII. Targeted Case Management Services

Payments made for targeted case management services will not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

A. Clients Manifesting Pathology with Human Immunodeficiency Virus (HIV).

Payment is a monthly case management fee as published, using a maximum allowable fee schedule.

B. Vulnerable Adults.

Contractor payment is on a capitation basis. The upper limit for payment for services provided on a capitation basis is established by ascertaining what other third parties are paying for comparable services under comparable circumstances. The unit rate for state staff delivered services is calculated based on historical costs.

D. Clients who are high-risk pregnant women and their infants living with them, up to age one.

Services are provided through the Maternity Case Management Program.

Payment is a case management fee as published, using a maximum allowable fee schedule.

D. Recipients under age 21 (not already serviced by a case manager) whose family or caretaker needs assistance in accessing the health care system.

Payment will be on a fee-for-service basis. The upper limit for payment for services provided on a fee-for-service basis is based on a rate negotiated by the state Medicaid agency.

For state staff, the rate will be based on the cost of service: All the expenditures associated with the delivery of TCM within a defined time frame divided by all the TCM units of services provided.

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XIII. Targeted Case Management Services (cont.)

E. Services for Clients Who are Alcohol and/or Other Drug Dependent

Payment will be on a fee-for-service basis. The upper limit for payment for services provided on a fee-for-service basis is based on a rate negotiated by the department.

Payments made for targeted case management services will not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

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XIV. Hospice Services

A. Payment for hospice care is made to a designated hospice provider based on a daily rate. The rates are contingent on the type of service provided that day. The rates are based on the Medicaid guidelines and are wage adjusted.

The department pays the lesser of the usual and customary charge or a fee based on a department fee schedule, for the professional service provided for pediatric palliative care.

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XV. Personal Care Services

A. Payment for services

Services are provided by three provider types:

- Agencies providing personal care services for adults, consisting of licensed home-care agencies and residential care providers;
- Licensed foster care homes providing personal care for children; and
- Individual providers of personal care for adults.

Payment for agency-provided services and licensed foster care providers is at an hourly unit rate, and payment for residential-based services is at a daily rate. Each agency will submit monthly billings to the Social Services Payment System (SSPS), administered by the department, for personal care services provided in each service area.

Payment for an individual provider's services is made directly to the provider via the SSPS. Individual providers of personal care services for adults are under contract to the department.

No payment is made for services beyond the scope of the program or hours of service exceeding the department's authorization. Payments to licensed foster care providers and residential providers are for personal care services only, and do not include room and board services that are provided.

B. Service Rates

The standard hourly rate for agency-provided services is based on comparable service units and is determined by the state legislature.

The standard hourly rate for individual-provided personal care is based on comparable service units and is determined by the state legislature, based on negotiations between the union representing the workers and the state's In-Home Quality Authority.

Foster parents are paid a standard hourly rate for any Medicaid Personal Care (MPC) eligible service, except supervision. MPC is not used to pay for food, clothing, or shelter. In the assessment of any child's needs, there is no duplication of services between programs.

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XV. Personal Care Services (continued)

The daily rate for personal care provided in a residential setting is case mix adjusted and based on typical costs for comparable service units, as determined by the department.

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XVI. Federally Qualified Health Centers

Effective January 1, 2001, the payment methodology for Federally Qualified Health Centers (FQHCs) conforms to Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. Under BIPA 2000, all FQHCs that provide services on or after January 1, 2001 and each succeeding year, are reimbursed on a prospective payment system (PPS) or an accepted alternative methodology.

BIPA 2000 allows for payment to an FQHC using an alternative methodology to the PPS, as long as the alternative methodology results in a payment to the center that is at least equal to the PPS payment rate.

This alternative methodology must be agreed to by the State and each FQHC, and documentation of each center's agreement must be kept on file by the State.

If an individual FQHC does not agree to be reimbursed under this alternative methodology, the FQHC will be paid under the BIPA PPS methodology. Effective for dates of service January 1, 2001 through December 31, 2001, each FQHC agreed to an alternative methodology that provided payments at least equal to the amount the center was entitled to under BIPA PPS. Effective for dates of service on and after January 1, 2002, the State will fully implement the PPS methodology as described in BIPA 2000.

Using the PPS methodology, the payment is set prospectively, using a weighted average of 100 percent of the center's total reasonable costs for all Medicaid-covered services as defined in the State Plan for calendar years 1999 and 2000, and adjusted for any increase or decrease in the scope of services furnished during calendar year 2001, to establish a base encounter rate. A center may choose to allocate applicable costs and encounters to specific services such as dental, mental health, etc., and establish a separate encounter rate for these services. The encounter rates are determined using each center's audited cost reports and each year's rate is weighted by the total reported encounters. Since the FQHC cost reports are completed using the centers' fiscal years, the cost reports will be adjusted to a calendar year. The formula used to calculate the base encounter rate for a clinic is as follows:

For example, for a center with a Fiscal Year end of March 31:
R = Rate; E = Encounters

$$\text{Base} = \frac{(((FY99R*FY99E)/12)*3)+(FY00R*FY00E)+(((FY01R*FY01E)/12)*9)}{((FY99E/12)*3)+(FY00E)+((FY01E/12)*9)}$$

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XVI. Federally Qualified Health Centers (continued)

A change in scope of service is defined as a change in the type, intensity, duration and/or amount of services. A change in the scope of service will occur if: (1) the center adds or drops any service that meets the definition of FQHC service as defined in section 1905(a)(2)(C) of the Social Security Act; and, (2) the service is included as a covered Medicaid service as defined in the State Plan Amendment.

The center is responsible for notifying the FQHC Program Manager in writing of any changes during the calendar year, no later than 60 days before the effective date of the change. Within 60 days of notification, the State will verify the change meets the definition of change in scope of service.

If the change represents a decrease in scope of service, the State will recalculate the base encounter rate by decreasing it by the average cost-per-encounter detailed in the center's 1999 and 2000 cost reports. If the change represents an increase in scope of service, the State will recalculate the base encounter rate on an interim basis by increasing it by the average statewide cost-per-encounter as detailed in the 1999 and 2000 cost reports from other centers that provide the service. Once the center can demonstrate its true costs of providing the service, it must submit adequate documentation of the costs to the State. The State will perform a desk review of the costs to determine if the costs are reasonable and necessary, and adjust the interim rate by the accepted cost-per-encounter to establish a final encounter rate. The new encounter rate(s) will be effective on the date the new service was fully implemented and available.

Beginning in calendar year 2002 and any year thereafter, the encounter rate is increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted for any increase or decrease within the center's scope of services. The MEI for primary care services will be applied to all types of encounter rates established for the center.

FQHCs receiving their initial designation after January 1, 2001 will be paid an average encounter rate of other FQHCs located in the same or adjacent area with similar caseloads, on an interim basis.

Within three years of receiving its initial designation, the FQHC must demonstrate its true costs using standard cost reporting methods, to establish its base encounter rate. The State will audit the new center's cost report to insure the costs are reasonable and necessary.

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XVI. Federally Qualified Health Centers (continued)

The new FQHC will receive this rate for the remainder of the calendar year in which it is established and will receive the MEI increase each year thereafter, using the defined methodology.

If two or more FQHCs merge after implementation of PPS, a weighted average of the centers' encounter rates is used as the encounter rate for the new center. For clients enrolled with a managed-care contractor, the State will pay the center a supplemental payment on a per-member-per-month basis, in addition to the amount paid by the managed-care contractor, to ensure the center is receiving the full amount it is entitled to under the PPS methodology.

The supplemental payment is the difference between the payments the center received from the managed-care contractor and the payments the center would have received under the PPS methodology. This supplemental payment is paid at least every four months. Until final audited cost reports for 1999, 2000, and 2001 (if applicable) are available for all FQHCs, and final base encounter rates are established, the centers are paid using an interim encounter rate comprised of the most current available cost information. The State will perform a reconciliation and settle any overpayments or underpayments made to the centers, retroactive to January 1, 2002.

Covered services provided to Medicaid-Medicare patients are reimbursed as detailed in Supplement 1 to Attachment 4.19 (B), pages 1, 2, and 3.

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XVII. Medical Services Furnished by a School District

Reimbursement to school districts for medical services provided the usual and customary charges up to a maximum established by the state.

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XVIII. Mental Health Services

Mental health fee-for-service rates are developed, if needed, using the methodology below. The department pays the lesser of the usual and customary charge, or a fee based on a department fee schedule.

To develop fees under the one-month constraint, the Mental Health Division relies on a unit value approach similar to Medicare. Using fee schedules from other states' Medicaid programs, the Medicare fee schedule, and 50th percentile commercial fees, the division constructs relative costs by code. These costs establish unit values by procedure code.

Next, a utilization-weighted, average charge is computed for the list of codes. A similar average is computed for Medicare and commercial fees as benchmarks. The Mental Health Division must then make a policy decision as to the level of proposed fees compared to these benchmarks. The division can then compute a conversion factor to achieve the desired outcome. This is similar to the benchmarking analysis performed by the Medical Assistance Administration on a regular basis as part of their review of the reasonableness of provider reimbursement under the Medicaid fee schedule.

The Mental Health Division expects that some gaps may exist in the comparison fee schedules, resulting in no unit values for certain services, from the first step of the rate development process. Additional steps are taken to fill these gaps, such as an examination of raw claim data from commercial, Medicare, and Medicaid sources, to construct reasonable relative fees.

See chart on next page.

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XVIII. Mental Health Services (continued)

Modality	**Billing Unit**	**In facility**	**Out of Facility**
Brief Intervention Treatment	¼ hour		
Crisis services	¼ hour		
Day Support	¼ hour (maximum of 5 hours per day, 5 days per week, per person)		
Family treatment	¼ hour		
Freestanding Evaluation and Treatment	Daily rate (excludes room and board)		
Group treatment services	¼ hour		
High Intensity Treatment	¼ hour for each covered staff		
Individual Treatment Services	¼ hour		
Intake evaluation Brief or Intensive	¼ hour		
Medication Management Group or Individual	Per person per event		
Medication Monitoring	Per person per event		
Mental Health Service in a Residential setting	Daily rate (excludes room and board)		
Peer Support	¼ hour not to exceed four hours per person per day		
Psychological Assessment	¼ hour		
Rehabilitation Case Management	¼ hour		
Special population evaluation	¼ hour		
Stabilization Services	1 hour	NA	
Therapeutic psychoeducation	¼ hour		